No.88-2043

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1989

GERALD L. BALILES, et al.,
Petitioners,
vs.
THE VIRGINIA HOSPITAL ASSOCIATION,
Respondent.

ON PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

BRIEF FOR GRAY PANTHERS ADVOCACY COMMITTEE, NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM, TAMMY STEEVES, EVELYN SERRANO, GEORGE ANNAS, PROFESSOR OF LAW AT BOSTON UNIVERSITY, SYLVIA A. LAW, PROFESSOR OF LAW AT NEW YORK UNIVERSITY, RAND E. ROSENBLATT, PROFESSOR OF LAW AT RUTGERS UNIVERSITY, KENNETH R. WING, PROFESSOR OF PUBLIC HEALTH AND PROFESSOR OF LAW AT THE UNIVERSITY OF NORTH CAROLINA, KAREN A. ROTHENBERG, PROFESSOR OF LAW AT UNIVERSITY OF MARYLAND, AS AMICI CURIAE SUPPORTING RESPONDENT

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STATEMENT OF INTEREST

Pursuant to Supreme Court Rule 36, counsel for the petitioners and respondents have consented to the filing of this brief amici curiae. Their letters of consent have been filed with the Clerk of the Court.

Amicus curiae Gray Panthers Advocacy Committee is an affiliate of the Gray Panthers, with members residing in seven States and the District of Columbia. A majority of the Advocacy Committee members receive benefits under the Social Security Act; the Committee's major focus is representing the interests of low-income elderly people. Health issues, especially access to services for low income, minority, and disabled individuals, are a priority for the Gray Panthers Advocacy Committee and for the Gray Panthers.

Amicus curiae National Citizens' Coalition for Nursing Home Reform is a fourteen-year old organization comprised of 300 local member groups and many individuals, including nursing home residents actively involved in nursing home reform and advocacy throughout the United States. Coalition members have a keen interest in

being able to assert the rights of nursing home residents under the Medicaid law in federal court.

Amici curiae Tammy Steeves and Evelyn Serrano are Medicaid recipients and named plaintiffs in a class action currently pending in a California District Court. Clark v. Kizer, No. 87-1700-LKK JFM (E.D. Cal., filed Dec. 7, 1987). This suit has been brought pursuant to 42 U.S.C. § 1983 and concerns the severe unavailability of maternity and dental care for Medicaid beneficiaries in California. The class relies, in part, on Medicaid laws that require states to assure that Medicaid beneficiaries have access to health care providers at least to the extent such access is available for the general population. See, e.g., 42 C.F.R. § 447.204.

Amici curiae George Annas, Professor of Law at Boston University, Sylvia A. Law,

Professor of Law at New York University, Rand E. Rosenblatt, Professor of Law at Rutgers University, and Kenneth R. Wing, Professor of Public Health and Professor of Law at the University of North Carolina, are professors of health law. They are the authors of a forthcoming textbook on health law, American Health Law (January 1990) (Little, Brown & Co.). Karen H. Rothenberg is the Director of the Law and Health Care Program at the University of Maryland Law School. In their capacities as teachers and as practicing attorneys, these law school professors have an interest in the Medicaid program and beneficiaries' access to health care.

SUMMARY OF ARGUMENT

This case concerns Title XIX of the Social Security Act, commonly called the Medicaid Act. 42 U.S.C. § 1396a et seq. The Court is being asked to decide whether the Medicaid Act, particularly 42 U.S.C. § 1396a(a)(13)(A), confers on health care providers an enforceable right under 42 U.S.C. § 1983 to challenge the adequacy of state Medicaid reimbursement rates to hospitals.

In their briefs, the Petitioner and National Governors' Association imply that beneficiaries, as well as providers, cannot sue under 42 U.S.C. § 1983 to enforce rights under the Medicaid Act. Petitioner's Brief ("Br.") at 12; National Governors' Association Br. at 13-14. This Court, however, should not reach the issue of

recipients' rights under 42 U.S.C. § 1983 (hereinafter "Section 1983"). This issue was not disputed below and goes far beyond the scope of the question on which the Court granted review. If, however, the Court chooses to review the question of recipients' rights, long-standing decisions by the Court leave no doubt that recipients can bring civil rights actions for violations of their rights under the Social Security Act.

Turning to the issue that is properly before this Court, amici urge the Court to uphold the hospitals' right under Section 1983 to enforce the rate provisions of the Medicaid Act. This independent right of enforcement is important because, without it, increasing numbers of providers will terminate participation in the Medicaid program. Medicaid provider participation is already reaching critically low levels in many parts of the country, particularly

in rural and inner-city areas. Placing restrictions on providers' ability to challenge their reimbursement rates will only exacerbate this problem.

ARGUMENT

I. RECIPIENTS HAVE THE RIGHT TO ENFORCE THE MEDICAID ACT UNDER SECTION 1983.

This case does not raise the issue of whether Medicaid recipients can sue under Section 1983 for violations of the Medicaid Act in general or the Boren Amendment in particular.[1] Of the four questions

[1] Petitioners mistakenly assert that this case raises the same issue as Coos Bay Care Center v. Oregon Dep't of Human Resources, 803 F.2d 1060 (9th Cir. 1986), cert. granted, 107 S.Ct. 1970 (1987), vacated and remanded on the issue of mootness, ___ U.S. ___, 108 S. Ct. 52 (1987). This earlier case raised the issue of whether Medicaid providers and their patients could bring a civil rights action for violation of the Boren Amendment.

originally raised by Petitioners, this Court only agreed to decide whether "a Medicaid provider [has a] private federal cause of action under 42 U.S.C. § 1983 to enforce [the] Medicaid Act against the State." 55 U.S.L.W. 3021, 3213. (Emphasis added.) This question for review does not fairly include the quite different and important issue of whether a Medicaid beneficiary can bring an action under Section 1983 for a state's violation of the Medicaid Act. See U.S. Sup.Ct. Rule 21.1(a). It would be particularly inappropriate for this Court to address any issues involving Medicaid recipients' rights in this case inasmuch as these issues were not raised in the court below. See Youakim v. Miller, 425 U.S. 231, 234 (1986); Delt. Air Lines, Inc. v. August, 450 U.S. 346, 362 (1981).

Unfortunately, however, the Brief of Petitioners (at 12) and the Brief of the

National Governors' Association, et al., as Amicus Curiae in Support of Petitioners (at 13-14) attempt to bootstrap the broader argument that no private party can bring a Section 1983 action to challenge violations of the Boren Amendment. Because they have interjected a new question which directly affects Medicaid beneficiaries' rights, amici curiae feel obligated to respond briefly on this subject.

The Medicaid program was established in 1965 to provide federal financial assistance to states for furnishing medical treatment to needy persons. Schweiker v. Hogan, 457 U.S. 569, 571 (1982). 42 U.S.C. § 1396 expressly authorizes federal funding to the states so that they will provide medical assistance to "families with dependent children" and "aged, blind or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services. . . ."

Regardless of the parties' differences in this case, there is at least agreement that recipients are the intended beneficiaries of the Medicaid Act. Indeed, Petitioners expressly argued in the Court of Appeals that recipients have enforceable rights under the Medicaid Act. Virginia Hospital Ass'n v. Baliles, 868 F.2d 653, 656 (4th Cir. 1989). So, too, 46 other states are now arguing in this Court that the only "intended beneficiaries of the Social Security Act are the recipients of benefits. . .." Brief Amici Curiae of the States of Connecticut, et al., at 2-3 (and the cases cited therein); see also National Governors' Association Br. at 3 (Medicaid program "designed to provide health care services to the poor").

This Court has long recognized that beneficiaries can bring actions under Section 1983 to enforce their rights under

the Social Security Act. Maine v. Thiboutot, 448 U.S. 1, 4-8 (1980); Edelman v. Jordan, 415 U.S. 651, 675-677 (1974); Rosado v. Wyman, 397 U.S. 397, 420 (1970) ("We are most reluctant to assume Congress has closed the avenue of effective judicial review to those individuals most directly affected by the administration of its program"). Like the Aid to Families with Dependent Children program described in Rosado and Thiboutot, the Medicaid program is a cooperative federal-state program built around a state plan under which the state must meet numerous specific federal requirements. Compare 42 U.S.C. § 602(a) and (b) with 42 U.S.C. § 1396a(a) and (b).

Thus, this Court has decided several cases brought by Medicaid beneficiaries against state officials for alleged violations of the Medicaid Act. Atkins v. Rivera, 477 U.S. 154 (1986); Herweg v. Ray, 455 U.S.

265 (1982); Harris v. McRae, 448 U.S. 297 (1980).[2/] In Blum v. Stenson, 465 U.S. 886 (1984), this Court also considered the related issue of how to determine an appropriate attorneys' fee award under 42 U.S.C. § 1988 for Medicaid recipients who had prevailed in their Section 1983 action against state officials.

Nevertheless, Petitioners and the National Governors' Association appear to argue that no private party, including a beneficiary, may bring a civil rights action for violations of the Boren Amendment. Quite recently, this Court in Golden State Transit Corp. v. City of Los Angeles,

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2/ The lower courts have also held that Medicaid recipients can bring suit under 42 U.S.C. § 1983. See, e.g., Weaver v. Reagen, 886 F.2d 194, 195 n.1 (8th Cir. 1989); Mitchell v. Johnston, 701 F.2d 337, 344 (5th Cir. 1983); Thomas v. Johnston, 557 F.Supp. 879, 902 (W.D.Tex. 1983) (upholding Section 1983 suit by Medicaid beneficiaries to enforce reimbursement provisions of 42 U.S.C. § 1396a(a)(13)(A)).

___U.S.___, 58 U.S.L.W. 4033 (U.S. Dec. 5, 1989), reiterated the two-part test for determining whether a particular violation of federal law falls within the broad coverage of Section 1983. First, the plaintiff must allege the violation of a federal right. Id. at 4034. Second, even where the plaintiff has asserted the violation of a federal right, the defendant may still demonstrate that Congress "specifically foreclosed a remedy" under Section 1983 by establishing a comprehensive enforcement mechanism for protection of this federal right. Id.

If the Court applies the two-part test in Golden State Transit Corp. to the Boren Amendment, 42 U.S.C. § 1396a(a)(13)(A), the legal issues nonetheless are quite different for beneficiaries than providers. For beneficiaries, their federal right rests upon the language in 42 U.S.C. § 1396a(a)(13)(A) that payment for hospital, skilled

nursing facility, and intermediate care facility services shall be through the use of rates "which the State finds, and makes assurance satisfactory to the Secretary, are reasonable and adequate to . . . assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality. . . ." (Emphasis added.)[3/] Providers, on the other hand, have relied on other language in this statute as establishing their federal right to reasonable reimbursements for providing inpatient care.

Turning to the second part of the test for Section 1983 actions, the Court once

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3/ In adopting the Boren Amendment, Congress did not intend "to encourage arbitrary reductions in payment that would adversely affect the quality of care." S. Rep. No. 139, 97th Cong. 2d Sess., reprinted in 1981 U.S. Code Cong. & Admin. News 744.

again must embark on a different analysis for recipients than providers as to whether the Boren Amendment, its legislative history, and HHS' implementing regulations, 42 C.F.R. §§ 447.250-447.280, were intended to create a comprehensive enforcement scheme in lieu of any remedies in federal court. The defendant in a Section 1983 action normally would bear the burden as to congressional intent. Golden State Transit Corp., 55 U.S.L.W. at 4034. Here, however, no party has assumed that burden or briefed this issue because, after all, beneficiaries did not bring this lawsuit. In sum, this case does not properly raise the question whether Medicaid beneficiaries, as opposed to providers, may sue under Section 1983 to enforce the provisions of the Boren Amendment.

II. DENYING HOSPITALS RIGHTS UNDER SECTION 1983 TO ENFORCE THE BOREN AMENDMENT WILL ADVERSELY AFFECT RECIPIENTS' ACCESS TO HEALTH CARE.

42 U.S.C. § 1396a(a)(13)(A) governs hospitals' reimbursement rates. Petitioners argue that providers' only mechanism to enforce this right is an administrative appeals process. 42 U.S.C. § 1396a(a)(37); 42 C.F.R. § 447.253(c). However, this administrative procedure is available only to resolve payment disputes between an individual provider and the state. It is not designed nor is it available to challenge the overall methodology of state reimbursement systems. Therefore, providers require access to the federal courts via Section 1983 in order to challenge states' unlawful reimbursement systems.

If hospitals are denied the right under Section 1983 to make these challenges, amici fear that hospitals will not accept Medicaid beneficiaries. Participation in the Medicaid program is purely voluntary; neither federal nor state Medicaid statutes require hospitals to admit Medicaid patients.[4/] Moreover, providers are already at financial risk when they accept Medicaid patients. Except for nominal fees that may be charged to certain beneficiaries, Medicaid reimbursement -- whatever it may be -- must be accepted as payment in full. 42 C.F.R. § 447.15.

[4/] The Medicare Act does require hospitals with emergency rooms to provide "stabilizing treatment" for emergency medical conditions and women in active labor. 42 U.S.C. § 1395dd. Furthermore, facilities that have accepted federal Hill-Burton grants and loans are required to participate in Medicaid. 42 C.F.R. § 124.603(c)(1)(ii).

Experience has shown that inadequate state reimbursement levels have, in many instances, presaged beneficiary access problems. Below, amici highlight some of these access problems to illustrate how any further disincentives to participation in the Medicaid program surely will result in diminished access for Medicaid beneficiaries.

1. Some Hospitals Serving Medicaid Recipients Have Gone Out of Business.

Approximately 300 public hospitals have closed since 1985. American Hospital Association, Hospital Closures 1980-1988 (January 10, 1989) (prepared by the AHA Hospital Data Center). Low Medicaid reimbursement has been a major factor leading to these closures. The situation in Chicago, Illinois is typical. There, severe limits on

reimbursement instituted under the Illinois Competitive Access and Reimbursement Equity ("ICARE") program contributed to the closure of eight hospitals in a three-year period. One such hospital, Mary Thompson Hospital, which depended on Medicare and Medicaid reimbursement for 80% of its patients, closed in the Spring of 1988. Several other hospitals reported that they were on shaky financial ground, as they "grapple[d] with too many Medicaid patients and not enough Medicaid funds." Carlsen, "Chicago Hospitals Faltering," Health Week, May 9, 1988, at 2, col. 2. A study of the ICARE system concluded that "the program places a greater importance on shaving dollars from hospital per diems in the short run. Clinical outcomes for patients served or long-range objectives for the hospital sector in Illinois seem less important, and this shortsightedness is the essence of the ICARE

program's shortcomings." Salmon, et al., "Reducing Inpatient Hospital Costs: An Attempt at Medicaid Reform in Illinois," 13 J. of Health Politics, Policy and Law 103, 120-21 (Spring 1988).

2. Some Hospitals Have Had to Engage in Behavior Aimed at Discouraging Medicaid Recipients From Obtaining Care.

Short of terminating participation in Medicaid, some hospitals have had to avoid Medicaid program losses by taking steps to discourage beneficiaries from seeking care at their facilities. For example, by closing obstetrical and emergency services, hospitals sever the primary entry points by which Medicaid beneficiaries ultimately obtain inpatient hospital care.5/

5/ National Association of Public Hospitals, America's Health Safety Net: A Report on the (cont. p. 21)

a. Some Hospitals Have Had to Close Emergency Services.

Hospital trauma and emergency room closures are a growing problem nationwide. In Los Angeles, seven of the county's 23 trauma centers closed during the last three years. Spiegel, "Emergency Rooms in U.S. Listed in Critical Condition," Los Angeles Times, July 25, 1988, at 1, col. 1. Over the last two years, 15 hospitals in Los Angeles closed or downgraded their emergency rooms. Reinhold, "Crisis in Emergency Rooms: More Symptoms Than Cures," New York Times, July 28, 1988, at 1, col. 2. Last summer, inner city hospitals serving a heavily low income population threatened to

5/ (cont. from p. 20)

Situation of Public Hospitals in Our Nation's Metropolitan Areas at 16 (Oct. 1, 1987) (emergency rooms are the primary source of low-income patient admission to hospital care).

close their doors to ambulances. Id. Similarly, in Miami, seven of eight hospitals have terminated their agreements to serve as "designated trauma centers" in their service areas, leaving Jackson Memorial Hospital, a county hospital, to handle the huge emergency burden alone. Id. New York City physicians report that overcrowding in the emergency system is creating "medical gridlock." Spiegel, "Emergency Rooms in U.S. Listed in Critical Condition," Los Angeles Times, July 25, 1988, at 1, col. 1. Hospital officials in all of these states attribute the dilemma, in part, to inadequate Medicaid reimbursement. Id.; Reinhold, "Crisis in Emergency Rooms: More Symptoms Than Cures," New York Times, July 28, 1988, at 1, col. 2.

b. Some Hospitals Have Had to Engage in Obstetrical Diversion.

Another method hospitals use to avoid Medicaid losses is so-called "obstetrical diversion." Under these programs, hospitals reject, or limit services to, pregnant women on Medicaid.

According to testimony before the California Medicaid Assistance Commission, more than 46,000 babies will be delivered at Los Angeles public hospitals this year by a system that can safely deliver only 35,000 babies. Garcia, "Obstetric Care Crises at Hand for County," Los Angeles Times, November 29, 1989, at B1, col. 1. The hospitals attribute most of their problems to restrictions in the Medicaid hospital reimbursement system which have caused private hospitals to refuse maternity

care to eligible beneficiaries. Id. The situation has deteriorated so much that Los Angeles is now developing a plan to turn pregnant women away. Id.

Meanwhile, in adjacent Orange County, the University of California Irvine Medical Center has experienced a deficit for the fourth time in six years. Stein, "Poor Patients May Put UC Hospitals in the Red, Regents Told," Los Angeles Times, June 17, 1989, at 36, col. 1. Much of the problem is attributed to chronic Medicaid underfunding. Id. To address the deficit, the Medical Center has developed an "obstetrical diversion" plan in which the facility deploys security guards to prevent Medicaid recipients who are in labor from entering the hospital's emergency room. Garcia, "Obstetric Care Crisis at Hand for County," Los Angeles Times, November 29, 1989, at B1, col. 1.

Medicaid recipients in rural Scott County, Tennessee, have also experienced "obstetrical diversion." Perl, "Where are the Children Born?" Washington Post, July 5, 1988, at 16, col. 1. There, pregnant women who live just a mile from the local public hospital must obtain care two hours away in Knoxville. Id. The local hospital terminated services for routine deliveries in 1984, citing the cost of the service; about 60% of the people who use Scott County Hospital are on Medicaid. Id. When Scott County closed its doors to pregnant women, the public hospitals in neighboring Claiborne and Campbell Counties did the same. Id.

3. Disproportionate Share Hospitals Depend on State Compliance With Federal Law to Maintain Financial Stability.

The vast majority of low-income patients receive their medical care in public hospitals, typically located in inner-city and rural areas. Congressional Research Service, Medicaid Source Book: Background Data and Analysis at 455-56 (Nov. 1988). According to the Medicaid Source Book, public hospitals serve a disproportionate number of low-income patients for two reasons. Id. First, private facilities in metropolitan areas avoid private subsidization of Medicaid losses by allowing the public hospitals to carry the burden of meeting the helath care needs of low-income patients. Id, at 456. Second, public hospitals are often located in areas with high concentrations of Medicaid beneficiaries and therefore are

more accessible to them. Id. Indeed, studies show that only "a handful of facilities treat a very high proportion of Medicaid patients, while the rest treat relatively few." Id. Without these facilities, there are no other facilities waiting to fill the gap. Feder & Hadley, Cutbacks and Care to the Poor: Will the Urban Poor Get Hospital Care? at 3 (May 1983).

Because these hospitals bear the principal responsibility for delivering care to low-income patients, their financial stability is often precarious. Medicaid Source Book at 455-456. According to an Urban Institute Report, approximately one-half of all public hospitals in the nation's 100 largest metropolitan areas operate at a deficit, despite governmental funding and private subsidies. National Association of Public Hospitals, America's Health Safety Net: A Report on the Situation

of Public Hospitals in Our Nation's Metropolitan Areas at iii (Oct. 1, 1987).

In 1981, Congress enacted as part of 42 U.S.C. §1396a(a)(13)(A), a requirement that states must make adjustments in Medicaid rates for hospitals that serve a disproportionate number of low-income patients. In enacting this section, commonly called the "disproportionate share provision," Congress recognized that these hospitals will not survive unless they are compensated adequately for delivering care to low-income persons. H.R. Rep. No. 158, 97th Cong., 1st Sess., at 294-96 (1981).

So far, the states' lack of compliance with the disproportionate share provision has been widespread, making rights of enforcement all the more important. After it was enacted, studies by the National Health Law Program in 1985 and by the Health Care Financing Administration in 1987 demonstrated

that the majority of states had failed consistently to implement the provision. S. Wilson, J. Waxman, "Restoring Meaning to the 'Disproportionate Number' Provision," 18 Clearinghouse Review 860 (Dec. 1984); Secretary of Health and Human Services, Report to Congress on Medicaid "Disproportionate" Hospitals (January 28, 1987).

In the Omnibus Budget Reconciliation Act of 1987, Congress tried to address this inadequate compliance by promulgating explicit standards regarding designation of and reimbursement to disproportionate share hospitals. Omnibus Budget Reconciliation Act of 1987, § 4112, Pub. L. No. 100-203, 101 Stat. 1330-148 (codified as amended at 42 U.S.C. § 1396a(a)(13)(A)). Nevertheless, in the history to the Omnibus Budget Reconciliation Act of 1989, Congress again remarked upon the states' sorry level of compliance. The House Committee noted that

a survey conducted by the Intergovernmental Health Policy Project in February 1989 revealed that the majority of states continue to fail to provide adequate reimbursement to disproportionate share hospitals. H.R. Rep. No. 247, 101st Cong., 1st Sess. at 481 (1989).

The disproportionate share provision is one of the few mechanisms that enables facilities to continue operations while accepting low-income patients. It is essential, therefore, that hospitals' rights to challenge states' compliance with the disproportionate share provision be preserved. Absent this right, disproportionate share hospitals have no other means to challenge unlawful state reimbursement systems. If public hospitals lose this ability to demand adequate rates, they may be unable to continue operating, and there will be no other facilities to fill the gap

for low-income patients.

CONCLUSION

This Court should hold that hospitals have the right to enforce 42 U.S.C. § 1369a (a)(13)(A) of the Medicaid Act pursuant to Section 1983. If the Court finds that hospitals have no such substantive federal rights, however, it should make clear that the decision does not affect the well-established right of recipients to enforce the Medicaid Act through Section 1983.

December 15, 1989

Respectfully submitted,

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